The Alaska Association on Developmental Disabilities
P.O.Box 241742
Anchorage, Alaska 99524-1742

To facilitate a united provider voice for best practices, advocacy, partnerships and networking.

Presentation to Medicaid Reform Advisory Group
July 30, 2014

I am grateful for this opportunity to speak to the Medicaid Advisory Reform Group. I greatly admire your goals of stability and predictability in budgeting, increasing the ease and efficiency of navigating the system by providers, and providing whole care for the patient by uniting physical and behavioral health treatment.

My name is Lizette Stiehr and I am the new Executive Director of AADD, the Alaska Association on Developmental Disabilities. We are a professional organization of approximately 40 organizations that offer Home and Community Based waiver services throughout Alaska. Our envisioned future is that we are a full partner with the State of Alaska and are proactive in addressing the needs of people with developmental disabilities. AADD's goal is to be a voice for Developmental Disability Providers, and in that role you can understand my gratitude for both your work towards the above goals and the opportunity to speak with you today.

In focusing on the goal of budgetary stability and predictability, all providers have experienced a significant increase in the cost of doing business, particularly in the area of hiring staff, from increased required training hours to background checks, state and federal fingerprinting, driving records and drug testing. The hiring costs for one direct service professional can be as much as $1,200. Currently, each of the hiring requirements must be replicated for each organization before a provider can begin working at their program. An example of a potential cost-saving measure is developing a universal worker who could work across the developmental disability system ; the hiring requirements could be centrally documented and not have to be duplicated for a second or third organization. The recent background check regulation revision that will allow such documentation to follow the worker rather than the organization is a great beginning.

Providers appreciate the fact that Medicaid has recognized the value of home and community based services in place of more institutional care, and the ability to bill for those community based services. Providers take that responsibility, to bill with integrity, with great seriousness. We support the identification and clearing up of any fraudulent or abusive billing of Medicaid. There are now multiple separate audits to which programs must respond. There are as many as seven different audits if agencies serve senior and behavioral health populations in addition to offering developmental disability services. This level of auditing requires programs to pour resources into providing documentation, and responding to questions and requests for

additional documentation. This administrative burden takes resources away from service delivery. We support the importance of identifying fraud and abuse. However, there is no recognition of those programs who are billing responsibly and accurately. We would propose that consideration be given to programs that have a history of clean audits. That consideration could allow programs with an error rate below 5% to bypass the next round of audits. Programs not showing improvement in their billing errors would require close monitoring and repeated audits.

Clearly Heath Care Services is doing a better job of finding where there is fraud or billing abuses taking place. We all read about those instances in the newspaper. That creates an image in the public eye of systemic abuses across all providers billing Medicaid, which is not accurate. Those of us striving to master perfection in thousands of claims, who are consistently working to do an ever better job of self-monitoring, would deeply appreciate recognition of that effort. Have error rates decreased over the period of increasing audits? If the audits are showing a global reduction of errors in the last five years, that figure would both provide support to the work of the Division of Health Care Services as well as the programs offering services. And announcing that reduction would balance the current newspaper coverage.

AADD recognizes how we are an interwoven system providing valuable services to Alaskans. We strongly support the work of the Medicaid Reform Advisory Group. We recognize the efforts by the Governor and the Department of Health and Social Services to handle Alaska resources efficaciously while providing services that matter to Alaskans. And we appreciate very much, the opportunities given to our system of providers to participate in that process through the Division of Senior and Disability Services, the Office of Rate Review and Heath Care Services. We are grateful to have been be a very active part of the work groups established after the July 1, 2013 Alaska Waiver Regulation implementation. Providers served on the respite, transportation and telehealth work groups. The last group in particular offers the potential for cost savings through the utilization of telehealth technology, saving substantially on staff time and travel costs. Representatives of AADD have participated in the Automated Service Plan project. AADD is pleased to be working closely with Office of Rate Review through the Rate Setting Partnership where small groups are working with the state to develop consistent definitions for individual and group services. We look forward to the Forums sponsored by Senior and Disability Services in mid-August to comment on the CMS Final Rule comments. We are eager to continue working closely with the Department, through pilot projects, feedback and committees.

Once again I appreciate this opportunity to say thank you for your work on behalf of Alaskans and provide some suggestions that will serve us all.

Sincerely,

Lizette Stiehr

Lizette Stiehr, M.A.
Executive Director, AADD

Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

907.562.6006 · 907.563.2001 · 4000 Ambassador Dr, Suite 101 · Anchorage, Alaska 99508 · www.anhb.org

July 28, 2014

Medicaid Reform Advisory Group
Medicaid.Reform@alaska.gov

Commissioner William Streur
The State of Alaska
Department of Health and Social Services
3601 C Street, Suite 902
Anchorage, AK 99503-5924

Dear Members of the Medicaid Reform Advisory Group:

Thank you for the opportunity to respond to the Medicaid Reform Advisory Group's (MRAG) request for public comment. I write on behalf of the Alaska Native Health Board (ANHB), the statewide voice on Alaska Native health issues. Established in 1968, our 26 member organizations deliver health care programs and services to the approximately 144,000 American Indian and Alaska Native people residing in the state of Alaska. ANHB's ongoing purpose and mission is to promote the spiritual, physical, mental, social, and cultural wellbeing and pride of Alaska Native people.

We applaud the Governor's decision to address the unsustainable growth of the Medicaid program while ensuring that Alaskans are able to access health care services in their communities. The Alaska Medicaid program represents a significant cost driver for the State of Alaska as well as a driver of health outcomes for many Alaskans. The program also supports the organizations providing health care services in our communities. Because meaningful reform requires input and recommendations from a variety of stakeholders, we appreciate the Governor's commitment to building a Medicaid program that is sustainable for future generations.

The Alaska Tribal Health System

The United States has long maintained a government-to-government relationship with Tribes. Formed in treaties and the Constitution, this relationship has been given substance over 200 years through legislative statute, executive action, and case law. This relationship guides the process and substance of interaction between federal agencies and tribal governments while providing funding to carry out the federal government's Trust Responsibility of providing for the health, education, and wellbeing of American Indian and Alaska Native people in perpetuity.

The federal policy associated with this Trust Responsibility has evolved since the formation of the Union, most recently in the form of self-governance and self-determination, a policy defined in the Indian Self-Determination and Education Assistance Act of 1976. This Act provided for the gradual transition of health care delivery from federal to tribal ownership, reinforced with legislation allowing for self-governance agreements between Tribes and the U.S. Department of Health and Human Services. This policy began a shift that opened the door to greater tribal sovereignty and self-sufficiency for tribal communities.

Perhaps the most successful manifestation of this shift in policy is the Alaska Tribal Health System (ATHS). In assuming responsibility and administration of health care services previously carried out by the federal government, Alaska Tribes and Tribal organizations have built a comprehensive network of clinics and hospitals throughout the state, providing some of the most efficient and innovative care in the world. From telehealth technology and Dental Health Aide Therapists, to the Nuka Model of Care and Alaska's only Level II Trauma Center, the ATHS has shown success and the ongoing potential of tribal ownership and self-governance in improving the health and wellbeing of our people and communities. While the ATHS is of clear benefit to Alaska Native people, the rural village clinics that regional hub facilities each serve a specific geographic area and are often the only access to health care available for those living in rural Alaska, serving to benefit all Alaskans.

Collectively, the Tribes and Tribal organizations making up the ATHS operate over 180 village-based clinics, 25 sub-regional facilities, 6 Regional hospitals, and the Alaska Native Medical Center (ANMC). In addition to the voluntary collaboration between Tribes and Tribal organizations, the ATHS interacts in significant and collaborative ways with all other sectors of Alaska health care delivery. The scope of ATHS includes not only services to American Indian and Alaska Native people, but also services to non-Natives in remote locations and where the a tribal health provider has special expertise or capacity that other sectors cannot offer.

Despite these tremendous gains and achievements, Alaska Native people experience poorer health outcomes than non-Natives in Alaska and the overall U.S. population.[i] Access to basic infrastructure, including safe drinking water, reliable transportation networks, and a wide variety of social services taken for granted by the majority of those living in the U.S. continue to elude many Alaskans living in rural areas. In fact, the unique geography of Alaska makes access to many services, including that of health care, either cost prohibitive or simply nonexistent.

The Indian Health Service (IHS) continues to be the foundation for funding health care delivery for Alaska Native people. As opposed to the vast majority of federally-administered of funded health care delivery programs, the IHS annual appropriation is discretionary and not based on any per-capita or "level of need" methodology. When compared to other federally administered health care or benefit programs (e.g. Medicare, Federal Employee Health Benefits, Veterans Affairs) the federal government provides approximately 60% of the funding on a per capita basis. In 2013, the IHS per capita expenditures for patient health services were $2,849 compared to $7,717 per person for health care spending nationally.[ii] This lack of funding is seen in the reduced level and scope of services available, including: adult dental care; non-hospital skilled nursing care; rehabilitation and substance abuse treatment; and behavioral services.

Although the IHS has always been underfunded, the Congressional failure to enact legislation to prevent the sequestration of FY2013 appropriations compounded the problem, with the IHS subject to an across-the-board cut of $353 million dollars (approximately 8.2%). Among federal health care programs, IHS was the *only* agency subject to full sequestration, forcing an already strained system into reduced services, layoffs, and even facility closures. Across the nation, the resources to carry out 3,000 inpatient admissions and 804,000 outpatient visits have been cut.

Here in Alaska, the Southeast Alaska Regional Health Consortium was forced to close the Bill Brady Healing Center, an alcohol and drug treatment facility that was critical to ensure vulnerable Alaskans were able to get back on their feet while preventing far costlier medical services down the road.

The Yukon-Kuskokwim Health Corporation (YKHC) had to let go of 110 employees while 50 more vacant positions will not be filled. With a network of the regional hospital in Bethel, nine regional facilities, and 47 village clinics, YKHC is often the only provider of care in much of Southwest Alaska, a road-less region roughly the size of Oregon. Like many rural parts of the state, ATHS provides the only meaningful access to care for those living in villages and communities.[iii]

In a situation that is alarmingly consistent across Alaska, the Aleutian Pribilof Islands Association (APIA) has had to close clinics and suspend services due to inadequate funding, presenting a safety hazard to the employees and patients. When attempting to define access to care for vulnerable Alaskans, descriptions like these below show how varied and elusive a single definition of access can be.

- The interior of the clinic is in poor condition. Different rooms have pieces of baseboards and trim boards missing. The wood flooring inside the clinic entrance is weakened by rotting. Standing in this area causes the floor to buckle slightly.

- The floor under the water softener in the utility room has water damage. Additionally, pieces of flooring were missing in the utility room. Flooring must be constructed of material that is of sound construction, non- absorbent, durable and easy to clean.

- The exam room and emergency rooms are not accessible by stretchers due to the limited space and excess of stored items in the clinic hallway. At a minimum, three feet of clear door space must be available. Future renovations or construction will need to incorporate guidelines from the American Institute of Architects (AIA) to meet standards for design of health care facilities.

- The building was not uniformly heated. The furnace room temperature was 80oF. The heating system needs to be arranged to provide uniform heat throughout the building between 68oF and 72oF when occupied. The door to the furnace room/utility room was propped open due to the temperature. The furnace needs to be maintained in accordance with code and have regular maintenance performed to keep it running safely.

GAP Analysis

With regard to the gap analysis completed on June 9, 2014[iv], the goal is a "first step in a process that will ultimately address deficiencies in health care access for vulnerable Alaskans." The

report defines the current status of Alaska's safety net for non-Medicaid-eligible adult Alaskans that, among other deliverables, loosely define the gap population and associated gap in services while providing an overview of the safety net services and the funding that supports these services.

In listing the parameters for the gap population, IHS beneficiaries that are seen (or eligible to be seen) within the ATHS are excluded from this group. Although eligible IHS beneficiaries are excluded from the gap population, the report acknowledges the tribal health care providers are among the points of access where those falling into the gap population can access care.

Further on in the report[v], a comparison of services available at the Anchorage Neighborhood Health Clinic is made with smaller clinics, presumably typical of rural areas. Referencing a mammography-screening tool, the report notes that a "gap" emerges with equipment, as opposed to insurance coverage, being the limiting factor. In the next paragraph, preventative dental service options are mentioned, though they are appear focused on urban areas, with Anchorage mentioned specifically. The report also finds that access to primary and preventive care is more common verses inpatient care and specialist services that, with few exceptions, are available only in Anchorage, Fairbanks, and regional hubs.

Throughout the report, a pattern begins to emerge where an individual or community cannot simply be considered to be with our without "access" to a full range of health care services. Taking this point into consideration, it's critical that when we attempt to define the Alaskans with and without access to health care services, the groups cannot be categorized as a straightforward "yes" or "no." The report acknowledges this difficulty and points to a need for more location-specific data on services available to those who are uninsured.

In addition to this finding, a more accurate picture of health care access in Alaska would entail how a health care provider creates the capacity to provide care in the first place. Alluding to this relationship, the report states that uncompensated care is "identified as a significant burden by much of the private and tribal health systems."[vi]

While the focus of the MRAG is to ensure Alaska's Medicaid program is sustainable for the State of Alaska while providing access to health care for certain Alaskans, it's worth stating that when an Alaska Native person enrolled in Medicaid is seen at a Tribal facility the cost to the State of Alaska is roughly zero (as opposed to the overall Federal Medical Assistance Percentage (FMAP) of 51%, the State of Alaska receives 100% FMAP for Alaska Native patients seen in a Tribal facility is 100%).

The report recognizes the potential revenues that would build capacity and greater access, but acknowledges, "utilization does not always follow access, as only 40% of tribal Medicaid health care is delivered in the tribal system."[vii] This statistic presents a significant opportunity to strengthen the financial stability of the ATHS as well as the long-term viability of Alaska's Medicaid program. As a partner with the State of Alaska and DHSS, ATHS recognizes the benefits associated with increased utilization within the tribal system, providing a win-win for the State and Tribal health providers. As such, ANHB requests that, among the recommendations under consideration by MRAG, the State of Alaska engage in tribal consultation to formulate how to maximize the use of the ATHS for Medicaid services.

Understanding how nuanced a term like "access" can be, ANHB entirely supports Governor Parnell's goal of determining how Alaskans seek health care services and the capacity of health care organizations to provide these services. In working toward a solution that includes all of Alaska, it is important to remember that for much of Alaska, access is defined in disparate and, sometimes, conflicting ways. The delivery of health care in Alaska is a complicated matter, requiring solutions that work across a variety of settings. With a significant segment of Alaska's population using the Tribal health system, traditional notions of access and the relationship between patient and provider take on new elements, not all of which can be easily defined or categorized.

Looking forward, ANHB is excited for the opportunity to continue providing input to MRAG and strengthening our existing partnership with the State of Alaska and Governor Parnell. As we see it, our ability to reform the Medicaid program into a sustainable method for Alaskans to access health care services is critical to both the State's future physical, as well as, fiscal health. I thank you for the opportunity to provide written comments. Please do not hesitate to contact me (anhb@anhb.org, 907-562-6006) with any questions or if additional information can be provided.

Sincerely,

Lincoln Bean, Sr.
Chairman, Alaska Native Health Board

---

[i] Indian Health Service (IHS). IHS fact sheets: Indian health disparities [Internet]. Rockville, MD: IHS; 2011. www.ihs.gov/PublicAffairs/IHSbrochure/disparities.asp. Accessed Dec 11, 2012.

[ii] National Indian Health Board, Testimony to Senate Committee on Indian Affairs re: President's FY2015 Budget for Tribal Programs Washington DC; March 26, 2014.

[iii] KYUK. Alaska Public Media. YKHC CEO Releases Layoff Details [Internet]. http://kyuk.org/ykhc-ceo-releases-layoff-details/

[iv] Alaska Department of Health and Social Services. Gap Analysis Requested by Governor Parnell. June 9, 2014

[v] ibid. page 7

[vi] ipid. Page 11

[vii] ibid. Page 9

Andy Teuber
ANTHC Chairman and President

Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, Alaska 99508
907.729.1900
chairman@anthc.org

July 29, 2014

Medicaid Reform Advisory Group
Medicaid.Reform@alaska.gov

RE: Comments on Medicaid Reform in Alaska and the DHSS's report on the health care access gap

Dear Members of the Medicaid Advisory Reform Group:

The Alaska Native Tribal Health Consortium (ANTHC) submits these comments in response to the Department of Health and Social Services' (DHSS) recent health care access gap report and to provide more general recommendations on how Medicaid reform can be implemented to expand the access to, and quality of, health care provided to a great number of Alaskans.

ANTHC is a statewide tribal health organization that serves all 229 tribes and over 143,000 Alaska Natives and American Indians (AN/AIs) in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AIs in Alaska. ANTHC provides statewide services in specialty medical care, construction of water, sanitation and health facilities, community health and research, telehealth and information technology.

The DHSS gap report released on June 9, 2014, shows a concerning lack of understanding of the Alaska Tribal Health System (ATHS)[i], both in the scope of the services provided by the ATHS and the funding sources for those services. We hope our comments can help explain the ATHS and show how increased cooperation between the state and the ATHS can lead to an increase in the quality and quantity of health services accessible to a great number of Alaska while reducing the health care costs to the state.

While ANTHC maintains that Medicaid expansion would provide the most benefit to improving health care to the greatest number of Alaskans at a minimal cost to the state, there are other tribal-specific options that are distinct from the Medicaid expansion and the Affordable Care Act that can greatly benefit the state and a great many Alaskans.

DHSS undertook a monumental task in trying to ascertain the population of Alaskans who have no or limited health coverage. While we disagree with many of the findings of DHSS's gap report, we understand that its charge was difficult. Our comments address some of the shortcomings of the report, but our main issue with the report is that it does not address a more important question, which is—*How can*

Medicaid be reformed in Alaska to provide the greatest benefit to the greatest number of Alaskans at the least cost?

This is the question that we will provide a recommendation on first. Keeping in mind that the Medicaid Advisory Reform Advisory Group (MRAG) was tasked with meeting three reform mandates: (1) Stability and predictability in budgeting; (2) Increasing the ease and efficiency of navigating the system by providers; and (3) Providing whole care for the patient by uniting physical and behavioral health treatment.

Increased utilization of Tribal facilities to provide Medicaid services should be a critical part of Medicaid reform

The ATHS has a unique status within the larger Alaska health care delivery system in regards to Medicaid and the federal government that can be utilized to benefit Alaskans and the state. The federal government has a trust responsibility to provide health care to AN/AIs and the federal government provides 100% reimbursement to the state Medicaid program for qualifying services that are provided through a tribal facility. In contrast, the federal government, generally, only reimburses the state Medicaid program 50% of the cost of Medicaid services provided at non-tribal facilities.

This means that the more Medicaid services that are provided through tribal facilities—that would have otherwise been provided outside of ATHS facilities—the more funds the state's Medicaid program saves. Increased use of the ATHS to provide Medicaid services would also improve the ATHS due to the increased revenue that would be received by the underfunded ATHS. (Congress, in recognition that Indian Health Service (IHS) funding was insufficient, provided authority in the initial Indian Health Care Improvement Act of 1976, P.L. 94-437, for tribal health programs to directly bill Medicaid.)

The report notes that only 40% of Medicaid service provided to AN/AIs is provided in tribal facilities. Expanding opportunities for the ATHS to provide part of the other 60% of these services presents a huge potential for savings to the state Medicaid program. This would create a positive cycle, as more Medicaid revenue generated for the ATHS would allow it to expand capacity to provide more Medicaid services to the AN/AI population.

A prime example of this concept in action is the collaboration and support of the state in services expansion in the tribal continuum of care as a way to improve health care of Alaska Natives and save state general fund dollars. Active projects include the patient housing facility on the Alaska Native Medical Campus, long term care facilities within the ATHS, and a home- and community-based care pilot between the state and Tanana Chiefs Conference.

The design phase of the patient housing facility will be completed this summer, with construction scheduled to be completed by June 2016. Once operational, it is projected that the increase in capacity will save the state Medicaid program $8.8 million per year. This project was only possible through the excellent collaboration and assistance provided by Commissioner Streur, DHSS, the Department of Revenue, and with great support from the legislature and the governor.

The more such mutually beneficial arrangements can be made, the more all Alaskans benefit. Therefore, *we request the MRAG recommend to the governor that the state engage in tribal consultation to identify ways to maximize the use of tribal facilities for Medicaid services.*

If implemented this recommendation would help achieve all three key reform mandates MRAG is charged with meeting: (1) the savings to the state Medicaid program would clearly help stabilize the budget; (2) the ATHS is an integrated and comprehensive system for providing health care, with a well-established referral network that allows the ATHS to more easily and efficiently coordinate care and interact with Medicaid, for the AN/AI population, than non-tribal provider; and (3) the comprehensive and coordinated care provided by the ATHS also allows for better integration of physical and behavioral health treatment.

IHS funding for ATHS is far below the level needed to provide the level of service required

The report states that more than $10,000 was spent per Alaskan on health care in 2010. It also cites that that IHS provided $620 million in funding to tribal organizations in Alaska in 2012. The report failed to note that the IHS amount equaled only $4,324 per active AN/AI user served by the ATHS, which is only roughly 40% of the amount that was spent per Alaska on health care.[ii] This is consistent with the findings of IHS, which showed that nationwide in 2013 the average funding per IHS user was only 59% of that of a blend of Federal Employee Health Benefits.

Just one example of how IHS funding is inadequate is in facilities. According to IHS's 2012 Report to Congress on health care facilities, the average age of IHS-owned facilities is over 30 years and more than a third of IHS hospitals and health centers are over 40-years-old. This is in stark contrast to private-sector hospitals, where the average age is 9 to 10 years. As for tribal facilities, at the current rate of funding provided for IHS facilities construction it would take over 30 years to simply complete the projects on the current list before any new projects could be started.[iii]

The amount of funding that the IHS provides the ATHS is inadequate to fund the comprehensive health care services the ATHS delivers, let alone the community health services, health care and sanitation construction projects that it must undertake.

By far the primary area where the ATHS makes up for the shortfall in IHS funding is through billing of third-party payers (Medicare, Medicaid and private insurance), the largest of which is Medicaid. (As mentioned previously, Congress authorized IHS to collect for Medicaid and Medicare services to supplement IHS funding for tribal health programs and provided that such services would be 100% reimbursable to the states.[iv]) There are other sources of state and federal funding that make valuable contributions to programs that the ATHS undertake, but third-party collections is the most critical area of funding outside of IHS.

The DHSS gap report mischaracterizes the ATHS as a safety net provider

The report refers to the IHS funding that is provided in Alaska (all of which goes to the ATHS) as funding for organizations providing safety net services. While the ATHS may provide some safety net services, as described in the report, the ATHS is far more than a safety net provider. It provides coordinated, comprehensive health care to more than 143,000 Alaska Native people and to imply that the IHS funding is intended as funding for safety net services is quite misleading.

For example, as just one component of the ATHS, ANTHC co-manages the Alaska Native Medical Center, which features the highest level Trauma Center in Alaska and offers advanced cancer care, neonatal intensive care, neurosurgery, and inpatient children's care. In addition, we provide statewide service in specialty medical care; lead construction of water, sanitation and health facilities throughout Alaska; offer community health and research services; and information technology.

It is ANTHC's mission to provide the highest quality health care possible to all Alaska Native people. This is in stark contrast to the safety net services the report analyzes. The difference is best highlighted by examples cited in the report: DHSS cites a Mission of Mercy two-day clinic as providing safety net dental services to 800 Alaskans in Anchorage, which it counts as coverage. While the ATHS built the nation's first mid-level dental provider and training system, the Dental Health Aide Therapist (DHAT) program, which currently has 27 DHATs serving approximately 40,000 patients in 81 of Alaska's remote villages.

It must be noted that the DHAT program receives very minimal IHS funding support, and was primarily establish through the generous support of private foundations and its future is dependent on finding revenue source outside of IHS.

The report states that there are over 200 locations throughout the state where Alaskans without health care coverage can access services. Most of the locations listed in the report are village built clinics (there are over 180 total village built clinics) operated by the ATHS and villages. It is clear that village built clinics are a large piece of the safety net that DHSS envisions. However, DHSS may not be aware that many village built clinics are in jeopardy as the IHS lease payments they receive only cover one-third to one-half of the operating cost of the clinics.

Increased cooperation between the state and the ATHS is important for all Alaskans

The sustainability of the state Medicaid program and the success of the ATHS are closely related and dependent on each other. Increased cooperation between the state and the ATHS, which has already proven successful, can enhance health care quality and access for a great number of Alaskans while decreasing state spending.

I thank the MRAG members for their service on the Group and for the opportunity to provide comments regarding Medicaid reform in Alaska. I hope our comments will be informative to the Group as it completes its difficult task of providing recommendations to the governor on how to reform Medicaid to ensure an improved and sustainable Medicaid program. If you have any questions regarding our comments, or otherwise, please contact Jerry Moses, Senior Director of Intergovernmental Affairs, via e-mail: gmoses@anthc.org or phone: 907-729-1908.

Respectfully,

Andy Teuber
Chairman and President

---

[i] The Alaska Tribal Health System refers to the statewide voluntary affiliation of more than 30 tribal organizations that provides health services to Alaska Natives and American Indians through more than 180 village-based clinics, 25 sub-regional facilities, 6 regional hospitals, and the Alaska Native Medical Center.

[ii] Alaska 2011 and 2012 American Indian/Alaska Native & Non-Native IHS Active User Population Report (B), Versions 52 and 60, shows 143,389 active American Indian/Alaska users in Alaska for 2012.

[iii] The 2012 IHS Health Care Facilities Planned Construction Budget, http://www.ihs.gov//newsroom/includes/themes/newihstheme//display_objects/documents/RepCong_2012/HCF_Planned_Construction_Priorities_July_13_2012.pdf, shows $2.4 billion to complete current projects and IHS funding for new construction in FY 2014 was $79 million.

[iv] In 1976, Congress enacted title IV of the Indian Health Care Improvement Act (IHCIA) and amended Title XVIII, Medicare, and Title XIX, Medicaid, of the Social Security Act (SSA), allowing IHS to bill for medical services provided by IHS facilities to Indians eligible for Medicare or Medicaid. In order not to burden states with additional Medicaid expenditures, Congress provided 100% Federal reimbursement to States for reimbursements for services provided through an IHS facility to eligible AN/AI beneficiaries. [1905(b) of the SSA]

ASHNHA
ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

July 30, 2014

William J. Streur, Commissioner
Chairman, Medicaid Reform Advisory Group
PO Box 110601
Juneau, Alaska 99811-0601

Dear Commissioner Streur,

Thank you for the opportunity to provide comments at the July 30 Medicaid Reform Advisory Group (MRAG) meeting. I wanted to take the opportunity to memorialize ASHNHA's feedback in writing for the group.

On behalf of our members, I would like to thank the MRAG members for their work. Health care is an extremely complex industry, and within that Medicaid is an extraordinarily complex program. The work and timeline they were tasked with is difficult.

We support the efforts of the group and the commitment to improving Medicaid for those in the program. Clearly, the Department must weigh the overall impacts of any alternatives and strategies considered, as well as how changes could impact individual members and individual services provided. This is no small challenge. We appreciate that the Department provided a list of potential reforms; however, most of the items on this list are conceptual in nature. More detailed information would be required in order for us to provide meaningful feedback. In addition, receiving the list the Monday prior to a Wednesday meeting did not allow sufficient time for us to analyze the reforms and develop a substantive response.

ASHNHA members would welcome an opportunity for dialogue on the reforms identified by the Department. Should additional detail be made available about each concept, we would better be able to present our feedback or offer additional analysis and support. Given that, we offer the following recommendations:

Recommendations:

1. Because of the magnitude of this task, we suggest that the work of Medicaid reform must continue. Health care is changing rapidly – and to respond to those changes a process should exist to provide stakeholder feedback into the Medicaid program on an ongoing basis. Systemic, long-term improvement will only be realized through a continuous, well-resourced and managed effort.

2. We support the concept of primary care case management and we encourage the MRAG and the Department to further explore and outline what such a program might look like.

Utilization is the best target of opportunity for cost savings, and primary care case management is an important component of addressing utilization.

3. We urge the MRAG and the Department to address how to provide services to the gap population. We are concerned that the report provided to the group about the gap population is not comprehensive and makes assumptions that may not be accurate about access to health services in Alaska. It is clear that many Alaskans lack access to health insurance and some lack access to certain health care services. We believe that it is unacceptable for any Alaskan to suffer because he or she lacks the means to afford care. This is a difficult conversation to have without discussing Medicaid expansion, since many states are using Medicaid expansion as an opportunity to address comprehensive Medicaid reform. To forego consideration of alternative, innovative, forms of Medicaid expansion is to miss a significant opportunity to change the health care system for the better while providing care for the neediest among us. We would encourage the MRAG to look at Medicaid innovation through expansion in states such as Indiana, Pennsylvania, Arkansas and Michigan. If the group is not going to discuss Medicaid expansion, other options for the gap population should be addressed.

4. Little conversation has occurred about the regulatory and audit burden faced by health care providers, which grows every year. This burden directly increases costs, often without any demonstrable benefit. We encourage the group to look at how the state could streamline its own processes and reduce the burden of regulation where such regulations do not provide benefits to safety or program integrity.

5. Finally, we encourage the Department to continue to engage in conversations with providers. We believe that working together, we can address the state's needs for budget stability and predictability, while ensuring that Alaskans have access to high quality health care services. As previously stated, our association is open to conversations with the Department about how we can accomplish these objectives.

Thank you for the opportunity to provide comments. And thank you again to the MRAG members for their willingness to give their time to this important work.

Sincerely,

Becky Hultberg, Senior Vice President

Alaska Primary Care
ASSOCIATION

Commissioner William Streur,

Medicaid Reform Advisory Group

July 30th, 2014

The Alaska Primary Care Association's proposal for reform actions to be included in the final MRAG report and undertaken by the administration or the Alaska Legislature.

Dear Commissioner Streur and members of the Medicaid Reform Advisory Group,

The Alaska Primary Care Association (APCA) represents 50 organizations committed to providing excellent, accessible and integrated primary health care to Alaskans. Our largest membership category (over 50%) is the HRSA Section 330 funded Community Health Centers (CHCs); these represent 28 organizations that employ over 1400 people and operate more than 160 clinic sites through the CHC system. Alaska's tribal and non-tribal CHC sites serve approximately 100,000 people each year through over 500,000 separate visits, providing comprehensive, quality primary care. Currently approximately 37,000 of these patients have no health insurance.

The CHC system is a fundamental component of the Alaska health care delivery system, and acts as an indispensable partner in the provision of safety net service throughout the state. The CHC system works intimately with hospitals, DHSS, and the behavioral health community to provide accessible and quality primary care to Alaska's safety net population.

On November 15th 2013, Governor Sean Parnell announced a Medicaid reform strategy which established this commission, the Medicaid Reform Advisory Group (MRAG), and directed Commissioner Streur to develop a report defining the status of the non-Medicaid eligible Alaskans up to 100% of the Federal Poverty Level. Additionally, the Governor instructed the Commissioner to identify how best to address the issue of purely uncompensated care verse taxpayer subsidized care for this population. The MRAG is charged with recommending changes regarding three key reform mandates: 1.) Stability and predictability in budgeting; 2.) Increasing ease and efficiency of navigation the system by providers; and 3.) Providing whole care for the patient by uniting physical and behavioral health treatment.

Commissioner Streur has urged this commission and the external partners, AND stakeholders to be bold, and to think outside the box when addressing the three prong charge from Governor Parnell. To this end we recommend that you endorse in your final report the following actions to be undertaken by the administration or the legislature, which we believe represent the best possible opportunities to achieve the ends of our shared vision of a cost-efficient, sustainable healthcare system for Alaska.

1. ***State assistance for Patient Centered Medical Home (PCMH) recognition of all CHC sites in Alaska, within a 3-5 year timeframe***

    - The APCA believes this is the best opportunity to drive down healthcare costs in the long term and produce better health outcomes.
    - We won't change the outcome of high costs unless we change the system.
    - By-products of PCMH are behavioral health integration, care coordination, data management.
    - PCMH is also a gateway for payment reform.
    - PCMH practice change also allows for greater ease in development of regional relationships and partnerships and organizational structures.

2. ***Operational funding for primary care for the uninsured***

    - Currently, about 37,000 of the 100,000 patients at Alaska's CHCs have no insurance. To help CHCs cover the real costs of providing needed care to this population, the federal Health Center Program provides some operational funds through grants. But those funds don't close the entire gap, and CHCs rely upon a diverse profile of patient coverage – including Medicaid. Our health centers struggle to serve the existing uninsured population and remain financially sustainable.

    - The State of Alaska DHSS has provided a comprehensive list of grants awarded to CHCs across Alaska, totaling approximately $29 million per year (FY 2011-2013). Although these grants provide important supportive and enabling services to the CHC patient populations, none of them contribute to the provision of primary and preventive health services – the unique mission of CHCs.

3. ***Comprehensive payment reform***

    We urge the committee to support payment reform moving away from fee for service (FFS), and urge them to consider outcome based payments which consider acuity and specialty management. We urge the department to work quickly to undertake a pilot with CHCs, hospitals, and/or private payers and to advance a state plan amendment on payment reform.

4. ***Regulatory reform***

   - This committee should recommend all actions that allow for healthcare providers to be focused on the provision of healthcare. In this regard, the committee should recommend to the governor to direct the department to evaluate all regulations and audits that appear to providers to be duplicative based on similar federal submissions. The state should identify a way to achieve regulatory ends within existing reporting requirements.

5. ***Create a plan to address the balance of uncompensated care in Alaska***

   - Recommend that the governor create a plan to deal with the balance of uncompensated care remaining as an obstacle for people to manage their health matters if they are not insured or otherwise in "the gap".

6. ***Create a pathway to independent practice for physician assistants, and expand scope of practice for other professions (RN's LPN's etc)***

7. ***Decrease the cost of an Alaskan medical license or even waive the fee for all physicians, or for just military physicians.***

Thank you in advance for your consideration of the APCA's recommendations. I would be happy to speak to the MRAG at any of your upcoming meetings about any of the proposals contained in this letter.

Kind regards,

Nancy Merriman
Executive Director
Alaska Primary Care Association

In my experience up to this point I had a chance to interact with state employees with the Division of Behavioral Health, and when I asked specific questions about state Medicaid regulations the response I got was "I don't know the regs but this is how I suggest you do it...". The problem I found is the suggestions that person made, while well intentioned were not in accordance with the black and white of Medicaid regulations.

My main suggestion is if you are going to have rules, make sure those rules are widely and consistently promulgated and enforced. I appreciate the idea of working with providers rather than against them, a very positive approach. Just make sure in that approach the rules are consistently applied and enforced, if not then one cannot expect anything other than noncompliance.

Natalie Wolfe, CPPO, Administrator
Grants and Acquisition Services
Kenaitze Indian Tribe

I worked for 36 years as an RN before I was diagnosed with Progressive MS. I am in a power chair and have one functioning extremity. I appreciate the benefits I receive from the State of Alaska but find it curious that I pay for Medicaid. Under Alaska's Long Term Care Waiver program I receive more money than the allowable amount set by the legislature so the state takes the rest.

The LTCW program allows me to keep $1656 (or around that) and the rest of my Social Security check goes to the state. In 2013 my SS COLA was raised by 1.5% so the state upped my "cost of care" by 1.5%. I now pay $368/month, up from $356. It did not raise the base amount. The amount you allow me to live on has not been raised in 5 years!! My electric has sky-rocketed, groceries have increased in these 5 years, and my OTC medications have increased. I'm lucky to have family, friends and my church to help me.

The only service I receive is PCA services. Without that I would not be able to stay in my home and be a much greater burden on the state. The long term care facilities are sorely lacking in Alaska. I will pass away in my own bed in the state I call home.

Please increase the amount we few on this program get to keep. It has not been raised in at least 5 years.
Thank you,

Suzanne Cassens

Access Alaska is one of many organizations around the state that reuses and repurposes durable medical equipment (DME) that often was purchased by Medicaid on behalf of someone who, for a variety of reasons, no longer needs the equipment. We accept the used DME through donation, sanitize it and donate it back out to the community, saving Medicaid, Medicare and private insurance several hundred thousand dollars annually. Most of this DME is designed and manufactured to last many years, and can often benefit several people over its usable lifespan.

We would like to see the State adopt standards and payment methodology to sustain and expand this cost-saving approach.

If Medicaid were able to pay for used but safe, sanitary and functional DME rather than consistently purchasing new equipment, we believe the savings could be in the millions annually. Please consider this approach as one way to pragmatically and successfully reform Alaska's Medicaid system.

Respectfully,
J I M B E C K, MPA, Executive Director
Access Alaska, Inc.

---

1. IV sedation used only by board certified oral surgeons. Too many GP's are using this as a money tree.
2. Crowns can only be billed out after an x-ray submitted verifying that it was placed on the patient's tooth. I personally know a dentist that bills out for crowns when they are started but the crowns are never received by the patient.
3. Pay for sealants on molar teeth only.
4. 3+ surface fillings are taken from the patients annual funds.

Rick Kunz, D.D.S.
Mountain View Family Dentistry

To Whom This May Concern:

I am very concerned with the way things are done by the state concerning Medicaid. For 17 years out son has been in a wheelchair and what we have been through I would not wish on my worst enemy. My latest concerns are the agency's change of the paperwork the PCA's and his other help have to deal with all because the state wants more information.

Well if the hours for his care have been approved then why should every task done in every hour have to be documented? Every day his care is the same. Then his PCA agency said , when we asked when we were going to get a raise, that the state has not given a raise for three years and so not to expect one. A PCA is allotted no time for a coffee break or a meal. There is no vacation time or sick leave given. They have no incentive to stay in this field in fact every reason to get out of it. It is not easy work. I have been one of his PCA's for years. Trying to find good help is very hard, and it's hard to find people you trust so when you do find good people you do all you can to keep them. But what the state is requiring the agencies in paperwork which then falls on the workers is causing great concerns. If this wasn't our son I would not continue as a PCA.

Then for a number of years we have been buying Wills leg bags and night bags because we were told that Medicaid would not pay for them even with a prescription. They only gave him 2 day bags and 1 night bag a month. For years they did supply them then things changed and we had to pay for them now things have changed again and we were told that we didn't have to pay for them. We are constantly in a state of confusion concerning his supplies that he needs. One minute they pay and then the next it's up to us. When my husband and I leave the state we have to pay someone for the 27 hours a week that he has no care. He has to have someone here with him 24 hours as he goes into autonomic dysreflexia if his catheter is plugged or if he spasms and his feet fall of the feet rests or if there is a fire at night etc. His life has been spared so many times I cannot even count, because someone was with him.

Then the lady from the state that has been working to get Will's PCA hours cut, called his physician to try to get him to change the prescriptions for his care. I could go into a lot more on what she did but suffice it to say I am hoping to tell the Governor myself. Enough is enough! If the state would start eliminating all the

unnecessary people working the program then maybe people that need the care could get it. We have talked to a number of people in wheelchairs that need the help and hours for care but have no one to fight for them. This program is so flawed and a lot of it comes from the people running it.

Thank you
Marion Sands

The most effective means of controlling Medicaid costs should include the following:

1. Competitive Bidding on each and every scope and type of medical care services, equipment and procedures.
2. There should be an aggressive program put in place of regular investigative follow up ensuring that both "patient and provider" meet the requirement threshold standard set by the Federal Government and the State of Alaska in order to both qualify and receive benefits.
3. Medical equipment refurbishing should be considered where possible on all DME equipment for reuse in support of other claimants.
4. The State of Alaska should consider hiring more private investigative support as a follow up on those claiming "medical disability" resulting in long term benefits.
5. If the State of Alaska does not secure control over this program immediately, it will result in a financial disaster exceeding 8 to10% of the entire State budget.

Respectfully submitted,
Ross P. Bieling

Following are some random thoughts on the Medicaid system for your consideration:

1. Provide Medicaid benefits that mirror the essential health benefits as defined by the ACA.
2. Explore managed care for Medicaid beneficiaries including those receiving long term services and supports
3. Transition all Medicaid beneficiaries to the Exchange with the State of Alaska paying premiums for those who do not qualify for subsidies
4. Soft caps on all services (doctor's visits, well-child check-ups, home and community based services)
5. Discontinue "granting" of all health and social services, move to contracts to encourage free enterprise, competition and business approach to services. Along with this analyze if any of the grants can be refinanced to leverage additional federal dollars
6. Actively work with communities to consolidate and integrate providers of services to cut administrative costs. This will not happen naturally and will have an initial outlay to effectively work through the mergers and acquisitions - short term loss, long term gain.

Sandra J. Heffern, MRA, Effective Health Design
